

Notice of Independent Review Decision

April 19, 2010

Amended Date: April 21, 2010

DATE OF REVIEW: APRIL 19, 2010 Amended Date: April 21, 2010

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

To determine the medical necessity of a L1845 Ultimate Dynamic Brace.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

This reviewer is licensed by Texas Board of Chiropractic Examiners with 14 years of experience.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☐ Upheld (Agree)
- ☒ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

On March 20, 2009, M.D. evaluated the examinee. X-rays reported to be negative. Assessment: Knee pain.

On April 21, 2009, M.D., an orthopedic surgeon, evaluated the examinee. Impression: Traumatic osteoarthritis left knee. Chondromalacia patella with internal derangement left knee. Subluxing patella left.

On May 1, 2009, M.D., an orthopedic surgeon, performed a peer review on the examinee. Impression: The examinee sustained a sprain and strain of the left knee with possible lateral subluxation patella. In reasonable medical probability the degenerative changes in the left and right knees are related to ageing, weight, and the previous surgical intervention and repair reconstruction and therefore should be considered a pre-existing and non-compensable as related to this particular injury.

On May 1, 2009, M.D. re-evaluated the examinee. Impression: Internal derangement of the left knee.

On June 22, 2009, D.C. evaluated the examinee. Assessment: Left knee sprain with possible meniscus tear.

On July 22, 2009, M.D., an orthopedic surgeon, evaluated the examinee. Imaging: MRI shows a meniscus tear medially rather significant, probably the rim is torn, but he also has significant medial compartment traumatic osteoarthritis. The examinee has grade 4 changes medially and normal laterally and patellofemorally. Plan: Unicondylar knee replacement.

D.C. performed therapy on the examinee on 8/17/09, 9/15/09, 10/12/09, 11/10/09, and 12/8/09 with no significant change.

On January 5, 2010, M.D. performed a unichondylar zimmer knee replacement per the operative report.

On January 21, 2010, D.C. re-examed the examinee. Circumferential Measurements: Right 43.0 cm and Left 40.5. Flexion: 75° and Extension: +5°.

On January 27, 2010, Dr. performed a re-exam on the examinee. Imaging: X-rays show excellent alignment of the unicondylar knee replacement medially.

On March 4, 2010, D.C. responded to denial letter. In Dr. letter he states, "there is inherent instability and will continue to have inherent instability with this knee."

On March 15, 2010, M.D. evaluated the examinee. ADLs per Dr.: Due to pain he is only able to sit for 30 minute intervals. Pain restricts him from standing for

longer than 30 minute intervals. He is restricted to walk less than ¼ of a mile. Orthopedic Findings: Ballotment Test was found to be positive on the left indicating knee effusion. Plan: Active therapy and passive therapy.

On March 18, 2010, Mr. completed his 12 sessions of Post-Op Aquatic Therapy for his partial left knee replacement.

On March 22, 2010, D.C. evaluated the examinee. Left knee ROM: Flexion=130 and Extension=0. Diagnosis: Partial left knee replacement. Abnormality of Gait. Left knee pain.

PATIENT CLINICAL HISTORY:

The examinee injured his left knee while “getting off of the truck” and twisting his left knee. The examinee had a previous left medial meniscectomy in 2004. Status post unicondylar knee replacement on July 22, 2009, performed by, M.D.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

Knee braces are necessary only if the examinee is going to be stressing the knee under load. The criteria for the use of knee brace is for knee instability and to provide off-loading of the painful knee. Furthermore, a knee brace would increase confidence in an examinee’s ADLS, which may indirectly help with the healing process.

Documentation from ODG:

Knee brace	<p>Criteria for the use of knee braces:</p> <p><u>Prefabricated knee braces</u> may be appropriate in patients with one of the following conditions:</p> <ol style="list-style-type: none">1. Knee instability2. Ligament insufficiency/deficiency3. Reconstructed ligament4. Articular defect repair5. Avascular necrosis6. Meniscal cartilage repair7. Painful failed total knee arthroplasty8. Painful high tibial osteotomy9. Painful unicompartmental osteoarthritis10. Tibial plateau fracture <p><u>Custom-fabricated knee braces</u> may be appropriate for patients with the following conditions which may preclude the use of a prefabricated model:</p> <ol style="list-style-type: none">1. Abnormal limb contour, such as:<ol style="list-style-type: none">a. Valgus [knock-kneed] limbb. Varus [bow-legged] limbc. Tibial varumd. Disproportionate thigh and calf (e.g., large thigh and small calf)e. Minimal muscle mass on which to suspend a brace
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	2. Skin changes, such as: a. Excessive redundant soft skin b. Thin skin with risk of breakdown (e.g., chronic steroid use) 3. Severe osteoarthritis (grade III or IV) 4. Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain) 5. Severe instability as noted on physical examination of knee
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A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME
FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**